ONE MEMBER PER FORM

* REQUIRED FIELD

Member First Name: Last Name:

Relationship to Member: Self ☐ Parent ☐ Guardian ☐ Friend ☐ Lawyer ☐ Provider ☐ Other ☐

Does this person have permission to answer questions for the member? Yes ☐ No ☐

How are you submitting this form: Website ☐ Nursewise ☐ Provider ☐ Mail ☐ Fax ☐ Health Plan Staff ☐

If we would need to return a call to you, what is the best time and telephone number to reach you?

Morning ☐ Afternoon ☐ Evening ☐ Telephone number: ___ — ___ — ____

Primary Language if other than English:

1. Do you know who your Primary Care Doctor (PCP) is? Yes ☐ No ☐

PCP's Name:

PCP's Phone Number: ___ — ___ — ____

When did you last see your PCP? Less than 3 months ago ☐ More than 3 months ago ☐ Never ☐

Do you have an appointment scheduled with your Primary Care Doctor (PCP)? Yes ☐ No ☐

If Yes, when? (mmddyyyy):

2. If you are taking any medications do you have any questions about how to take them the way your doctor prescribed?

Yes ☐ No ☐

3. Do you have transportation to your doctor appointments? Yes ☐ No ☐

4. Are you aware of what an Urgent Care Center is? Yes ☐ No ☐

5. Do you know where the Urgent Care Centers in your area are? Yes ☐ No ☐

6. Have you been to the Emergency Room (ER) more than once in the last six months? Yes ☐ No ☐

7. Are you currently pregnant? Yes ☐ No ☐ IF YES, PLEASE COMPLETE A PREGNANCY FORM. THE FORM IS ON OUR WEBSITE AND INCLUDED IN YOUR MEMBER WELCOME PACKET.

8. Do you currently have any of the following conditions? (check all that apply)

- ☐ Anxiety
- ☐ Alcohol or Substance Abuse
- ☐ Asthma
- ☐ Autism
- ☐ Mental Illness: Schizophrenia, Bipolar Disorder, Post Traumatic Stress Disorder, Major Depression, Substance Abuse
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Congestive Heart Failure
- ☐ Developmental Disorder
- ☐ Diabetes
- ☐ Elevated Blood Lead Level
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Organ Failure such as End Stage Renal Disease or Liver Failure
- ☐ Sickle Cell
- ☐ Tobacco Use
- ☐ COPD
- ☐ Transplant (On waiting list, scheduled, or received within the last 12 months)
- ☐ Other Medical Condition(s) Please specify.

9. Do you have any special needs (such as hearing, vision or mobility problems)? Yes ☐ No ☐